PMG
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CONSENT TO TREAT POLICY
(including Gillick Judgement and Fraser Guidelines)

Introduction
The purpose of this protocol is to set out the practice's approach to consent and the way in which the principles of consent will be put into practice. It is not a detailed legal or procedural resource due to the complexity and nature of the issues surrounding consent.

Where possible, a clinician must be satisfied that a patient understands and consents to a proposed treatment, immunisation or investigation. This will include the nature, purpose, and risks of the procedure, if necessary, by the use of drawings, interpreters, videos or other means to ensure that the patient understands, and has enough information to give 'Informed Consent'.

Implied Consent
Implied consent will be assumed for many routine physical contacts with patients. Where implied consent is to be assumed by the clinician, in all cases, the following will apply:

- an explanation will be given to the patient what he/she is about to do, and why.
- the explanation will be sufficient for the patient to understand the procedure.

In all cases where the patient is under 18 years of age a verbal confirmation of consent will be obtained and briefly entered into the medical record.
Where there is a significant risk to the patient an "Expressed Consent" will be obtained in all cases (see below).

Expressed Consent
Expressed consent (written or verbal) will be obtained for any procedure, which carries a risk that the patient is likely to consider as being substantial. A note will be made in the medical record detailing the discussion about the consent and the risks. A Consent Form may be used for the patient to express consent and is always used by the practice when carrying out any minor surgery.

Obtaining Consent
Consent (Implied or Expressed) will be obtained prior to the procedure.
The clinician will ensure that the patient is competent to provide a consent (16 years or over) or has "Gillick Competence" if under 16 years. Further information about Gillick Competence and obtaining consent for children is set out below.

Consent will include the provision of all information relevant to the treatment.
Questions posed by the patient will be answered honestly, and information necessary for the informed decision will not be withheld unless there is a specific reason to withhold. In all cases where information is withheld then the decision will be recorded in the clinical record.

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The person who obtains the consent will be the person who carries out the procedure (i.e. a nurse carrying out a procedure will not rely on a consent obtained by a doctor unless the nurse was present at the time of the consent).
The person obtaining consent will be fully qualified and will be knowledgeable about the procedure and the associated risks.
The scope of the authority provided by the patient will not be exceeded unless in an emergency.
The practice acknowledges the right of the patient to refuse consent, to delay the consent, to seek further information, to limit the consent, or ask for a chaperone.

Clinicians will use a Consent Form where procedures carry a degree of risk or where, for other reasons, they consider it appropriate to do so (e.g. malicious patients).
No alterations will be made to a Consent Form once a patient has signed it.

Clinicians will ensure that consents are freely given and not under duress (e.g. under pressure from other present family members etc.).
If a patient is mentally competent to give consent but is physically unable to sign the Consent Form, the clinician should complete the Form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

There are other aspects which may be explained by the clinician and these include:
· Details of the diagnosis, prognosis, and implications if the condition is left untreated
· Options for treatment, including the option not to treat.
· Details of any subsidiary treatments (e.g. pain relief)
· Patient experiences during and after the treatment, including common or potential side effects and the recovery process.
· Probability of success and the possibility of further treatments.
· The option of a second opinion

Immunisations
Informed consent must be obtained prior to giving an immunisation. There is no legal requirement for consent to immunisation to be in writing and a signature on a consent form is not conclusive proof that consent has been given, but serves to record the decision and discussions that have taken place with the patient, or the person giving consent on a child's behalf.

Consent for children
Everyone aged 16 or more is presumed to be competent to give consent for himself or herself unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then he/she will be competent to give consent for him/herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign a Consent Form for themselves, but may like a parent to countersign as well.

For children under 16 (except for those who have Gillick Competence as noted above), someone with parental responsibility should give consent on the child's behalf by signing accordingly on the Consent Form.

The Gillick Judgement (Fraser Guidelines)

This concluded that a doctor would be justified in proceeding without the parents' consent or knowledge to give contraceptive advice, prescribe the contraceptive pill or fit a contraceptive device to a girl under the age of 16 if:

- The young person understands the health professional's advice
- The health professional cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice.
- The young person is very likely to begin or continue having intercourse with, or without, contraceptive treatment.
- Unless he or she receives contraceptive advice or treatment, the young person's physical or mental health, or both, is likely to suffer.
- The young person's best interests require the health professional to give contraceptive advice, treatment, or both, without parental consent.

Gillick Competence

This concept regards the consent of a child under 16 being regarded as valid where the above criteria are met. Children under 16 can consent to treatment only if they understand its nature, purpose, and hazards. To be able to consent the child should fully understand and appreciate the consequences of the treatment and equally failure to treat.

If a child under 16 is capable of consenting to treatment and does so, treatment may proceed. If a competent child under the age of 16 refuses treatment, it will not necessarily override authorisation given by someone who has parental responsibility for the child or the court. In such circumstances consider the age and emotional development of the child, the nature of the condition and the consequences to the child of the proposed treatment, and the effect on the child of the imposition of treatment against the child's wishes.

If a failure to treat would otherwise result in death or permanent injury, it is concluded that in spite of the child's refusal, treatment is justified in their best interests.

Parental responsibility

A mother automatically has parental responsibility for her child from birth.

A father usually has parental responsibility if he is married to the child's mother or listed on the birth certificate (after a certain date, depending on where in the UK the child was born).

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Parental responsibility can be applied for if you do not automatically have it.

For births registered in England and Wales:
If the parents of a child are married when the child is born, or if they've jointly adopted a child, both have parental responsibility. They both keep parental responsibility if they later divorce.

Regarding unmarried parents, an unmarried father can only get legal responsibility for his child in 1 of 3 ways:

- by jointly registering the birth of the child with the mother (from 1 December 2003)
- getting a parental responsibility agreement with the mother
- getting a parental responsibility order from a court

For births registered in Scotland:
A father has parental responsibility if he's married to the mother when the child is conceived or marries her at any point afterwards.
An unmarried father has parental responsibility if he's named on the child's birth certificate (from 4 May 2006).

For births registered in Northern Ireland:
A father has parental responsibility if he's married to the mother at the time of the child's birth.
If a father marries the mother after the child's birth, he has parental responsibility if he lives in Northern Ireland at the time of the marriage.

An unmarried father has parental responsibility if he's named, or becomes named, on the child's birth certificate (from 15 April 2002).

For births registered outside the UK:
If a child is born overseas and comes to live in the UK, parental responsibility depends on the UK country they're now living in.

Civil partners:
Same-sex partners who were civil partners at the time of the treatment will both have parental responsibility.

Non-civil partners:
For same-sex partners who aren't civil partners, the 2nd parent can get parental responsibility by either applying for parental responsibility if a parental agreement was made, or becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth

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Parental refusal of treatment

When a child is not considered "Gillick competent" it may be unlawful for a doctor to continue with treatment against the wishes of the child's parent or guardian. It is important to ensure parental authority is obtained before giving immunisations.

There are cases where the parents' wishes conflict with reasonable medical practice and are not it the best interests of the child. If after careful consideration is thought that the treatment should be given against the parents' wishes, a second opinion is strongly advised. How appropriate and available alternative measures are should be considered and a record made of the assessment and decision in the patient's clinical notes. The views of the parents will be an important factor in the decision.

Termination of pregnancy

When a girl is under 16, her parents should be consulted unless the girl forbids you to do so. You should obtain the patient's consent and the written authority of the parents. But their refusal should not prevent a lawful termination to which the patient herself consents, if the doctor is satisfied that the patient is mature enough to understand the nature of the operation, common complications and the issues involved.

Children in care

When a child is the subject of a care order, the local authority has parental responsibility under the Children Act and can authorise treatment on the child's behalf. But the order does not deprive parents of their parental responsibility or their ability to authorise or refuse treatment. The act makes it clear that the local authority has the power to decide the extent to which a parent or guardian may meet his responsibility.

References

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